Middlesex Medical Care, PC

Office of Perry L. Leong, M.D.

619 Union Avenue, Bldg. 1, First Floor

Middlesex, NJ 08846-1963

Phone: 732-356-3212 **Fax: 732-356-5002**

PLEASE FILL OUT ALL SIX (6) PAGES OF THIS FORM!!!

Date: _____

Patient Name: _____ Date of Birth:__/____/____

Street Address: _____

City, State, Zip Code: _____

Phone: (home)_____ (cell)_____ (work)_____

Social Security #: (on sticky note which will be returned to you) **Initials**: _____

Circle One:

Gender: Female or Male

Marital Status: Single / Married / Divorced / Widowed / Partner / Legally Separated / Other:_____

Employment: Employed-FT / Employed-PT / Self-Employed / Not Employed / Retired

Employer Name: _____Phone#: _____

Address: _____

****

{If you do not wish to answer, please write **REFUSED** in the space, Thank you!}

Ethnicity: _____ Race: _____

Preferred Language: _____

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Emergency Contact:

Name: _____ Relationship: _____

Address(if available):_____

Phone: _____ (home/work/cell)

****

Insurance Information:

(Please hand your cards to the staff if you have not done so already)

Primary Insurance:

Name of Insurance: _____ ID: _____

Claims Address: _____

Subscriber Name(if not yourself): _____ DOB: ___/___/_____

Subscriber Address: _____

Secondary Insurance:

Name of Insurance: _____ ID: _____

Claims Address: _____

Subscriber Name(if not yourself): _____ DOB: ___/___/_____

Subscriber Address: _____

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Calling permissions:

If it is necessary to leave a message when we call regarding any test results or medical information pertaining to the care given by

Middlesex Medical Care, PC and Perry L. Leong, M.D.,

I give permission to leave (**circle one**) **GENERAL** or **DETAILED** messages or if you do not have an answering machine, please circle **NO ANSWERING MACHINE**.

Furthermore, I give permission for the physician and the staff to speak with the following individuals regarding said testing and care:

The office has permission to speak with: _____

Relationship: _____ Phone: _____

PLEASE NOTE: INFORMATION REGARDING ANY HIV TESTING WILL ONLY BE GIVEN TO THE PATIENT ON WHICH THE TEST WAS PERFORMED WITH NO EXCEPTIONS MADE.

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Pharmacy Information:

Please provide us with the name of the pharmacy/pharmacies you use to have your prescriptions filled.

Name of Pharmacy: _____

Address of Pharmacy(CITY and STATE):_____

Phone # of Pharmacy: _____

Name of Mail Order: _____

Address of Mail Order: _____

Phone # of Mail Order: _____

****

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Electronic Medical Record System - EclinicalWorks

We have implemented a new Electronic Medical Record system to help our office run more efficiently. With the new system, we have several new services available.

Please fill out the information for the ones, in which, you are interested below.

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Rx consent:

Dr. Leong can access your prescription records from any pharmacy in the Nation prescribed by any doctor with your consent, that way you do not have to remember what you were prescribed by another doctor.

Will you give consent for Dr. Leong to have access to your prescription records from all doctors filled at any pharmacy in the United States? Circle one: Yes or No

Please sign:X_____ date:_____

****

Patient portal:

You will also have access to a patient portal, which will give you access to your visit summaries, blood work and updating your demographics online. You will have a username and password to access the patient portal.

To have access to the portal, please provide your email address:

_____

****An email with your username and password will be sent once the email address is added to your chart****

****

Automated Call System:

The Automated Call System will call you or send a text to the number you choose to confirm upcoming appointments. Please provide the number below:

Phone: _____(home/cell/work) **OR** **Text:** mobile#:_____

OR

You can **OPT OUT of the above calling program. However, you must understand that it is your responsibility to keep your scheduled appointment. You must further understand there is a $50.00 charge for failing to call the office and cancel the appointment. _____(initials)**

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Notice of Privacy Practices
Patient Acknowledgement

Patient Name:_____ **DOB**:_____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Type of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use of disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
    - The rights to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature:_____ Date:_____

Relationship to patient:_____

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PLEASE READ THIS NOTICE IN ITS ENTIRETY BEFORE SIGNING AS IT IS YOUR RESPONSIBILITY TO BE AWARE OF WHAT IS CONTAINED HEREIN

Name of patient: _____**DOB**: _____

I authorize medical and/or surgical treatment to be rendered by MIDDLESEX MEDICAL CARE, PC, including any of the physicians or their assistants on staff. I assume full responsibility for any charges that may result from this treatment. I understand that a billing charge of 6% per annum will be added to my account if not paid in full within 60 days of the date of service, and if this account is sent to a third party for collection, I will be responsible for any and all fees that are incurred for the collection process.

I understand that MIDDLESEX MEDICAL CARE, PC, may perform appointment reminder calls which are courtesy calls to remind me of my appointment. I can opt out of these reminder calls at anytime with written notice to the office listed above. I further understand that these calls are courtesy in nature only and it is my responsibility to remember my appointments. In the event, I am unable to keep my appointment, I am aware that it is my responsibility to call the office 24 hours in advance to cancel or reschedule my appointment. In the event that I fail to call to reschedule or cancel my appointment, this notice bears witness that I have been informed in writing, that there is a $50.00 charge for each un-cancelled missed appointment which is not reimbursable by my insurance and which will be due and payable from me.

I understand that it is my responsibility to notify this office of any changes in my insurance coverage as soon as possible after the change takes place. I also understand that many carriers have timely filing limits and if I do not notify this office of the insurance change and my claim is denied for timely filing that it is my responsibility to pay that claim in full myself.

I authorize my primary insurance, _____, and my secondary insurance, (if any)_____ to process claims on my behalf and authorize payment to MIDDLESEX MEDICAL CARE, PC and/or Perry L. Leong, M.D. I also authorize release of any medical information necessary to my primary insurance (listed above) and/or my secondary insurance (if any) (listed above) to process claims and request benefits in accordance with their program policy. All payments from my primary insurance (listed above) and/or my secondary insurance (if any) (listed above) should be made directly to MIDDLESEX MEDICAL CARE, PC or Perry L. Leong, M.D.

A copy of this authorization may be kept on file and may be used in place of the original.

I understand that I may revoke this authorization at any time in writing to the above listed address. Otherwise, this authorization will remain in effect until I revoke it in writing.

X_____Date:___/___/_____